TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
NEURO	357.5	ALCOHOLIC POLYNEUROPATH
NEURO	357.6	NEUROPATHY DUE TO DRUGS
NEURO	357.7	NEURPTHY TOXIC AGENT NEC
NEURO	357.8	INFLAM/TOX NEUROPTHY NEC
NEURO	357.9	INFLAM/TOX NEUROPTHY NOS
NEURO	358.0	MYASTHENIA GRAVIS
NEURO	358.2	TOXIC MYONEURAL DISORDE
NEURO	358.8	MYONEURAL DISORDERS NEC
NEURO	358.9	MYONEURAL DISORDERS NOS
NEURO	392	RHEUMATIC CHOREA
NEURO	430	SUBARACHNOID HEMORRHAGE
NEURO	431	INTRACEREBRAL HEMORRHAG
NEURO	432	INTRACRANIAL HEM NEC/NOS
NEURO	433	PRECEREBRAL OCCLUSION
NEURO	434	CEREBRAL ARTERY OCCLUS
NEURO	435	TRANSIENT CEREB ISCHEMIA
NEURO	436	CVA
NEURO	437	OTH CEREBROVASC DISEASE
NEURO	741	SPINA BIFIDA
NEURO	742	OTH NERVOUS SYSTEM ANOM
NEURO	851	CEREBRAL LACER/CONTUSION
NEURO	852	MENINGEAL HEM FOLLOW INJ
NEURO	853	OTH TRAUMATIC BRAIN HEM
NEURO	854	OTHER BRAIN INJURY
NEURO	907	LATE EFF NERV SYSTEM INJ
NEURO	950	INJ OPTIC NERV/PATHWAYS
NEURO	951	CRANIAL NERVE INJURY NEC
NEURO	952	SPINAL CORD INJ W/O FX
NEURO	953	INJ NERVE ROOT/SPIN PLEX
NEURO	954	INJURY OTH TRUNK NERVE
NEURO	955	INJ PERIPH NERV SHLD/ARM
NEURO	956	INJ PERIPH NERV PELV/LEG
ORTHO	170	MAL NEO BONE/ARTIC CART
ORTHO	171	MAL NEO SOFT TISSUE
ORTHO	213	BEN NEO BONE/ARTIC CART
ORTHO	274	GOUT
ORTHO	710	DIFF CONNECTIVE TISS DIS
ORTHO	711.00	PYOGEN ARTHRITIS—UNSPEC
ORTHO	711.01	PYOGEN ARTHRITIS—SHLDER
ORTHO	711.02	PYOGEN ARTHRITIS—UP/ARM
ORTHO	711.03	PYOGEN ARTHRITIS—FOREAR
ORTHO	711.04	PYOGEN ARTHRITIS—HAND
ORTHO	711.05	PYOGEN ARTHRITIS—PELVIS
ORTHO	711.06	PYOGEN ARTHRITIS—L/LEG
ORTHO	711.07	PYOGEN ARTHRITIS—ANKLE
ORTHO	711.08	PYOGEN ARTHRITIS NEC
ORTHO	711.09	PYOGEN ARTHRITIS—MULT
ORTHO	711.90	INF ARTHRITIS NOS—UNSPE
ORTHO	711.91	INF ARTHRITIS NOS—SHLDE
ORTHO	711.92	INF ARTHRITIS NOS—UP/AR
ORTHO	711.93	INF ARTHRIT NOS—FOREARM
ORTHO	711.94	INF ARTHRIT NOS—HAND
ORTHO	711.95	INF ARTHRIT NOS—PELVIS
ORTHO	711.96	INF ARTHRIT NOS—L/LEG
ORTHO	711.97	INF ARTHRIT NOS—ANKLE
ORTHO	711.98	INF ARTHRIT NOS—OTH SIT
ORTHO	711.99	INF ARTHRITIS NOS—MULT
ORTHO	712.80	CRYST ARTHROP NEC—UNSPE
ORTHO	712.81	CRYST ARTHROP NEC—SHLDE
ORTHO	712.82	CRYST ARTHROP NEC—UP/AR
ORTHO	712.83	CRYS ARTHROP NEC—FOREAR
ORTHO	712.84	CRYST ARTHROP NEC—HAND
ORTHO	712.85	CRYST ARTHROP NEC—PELVI
ORTHO	712.86	CRYST ARTHROP NEC—L/LEG
ORTHO	712.87	CRYST ARTHROP NEC—ANKLE
ORTHO	712.88	CRY ARTHROP NEC—OTH SIT
ORTHO	712.89	CRYST ARTHROP NEC—MULT
ORTHO	712.90	CRYST ARTHROP NOS—UNSPE
ORTHO	712.91	CRYST ARTHROP NOS—SHLDR
ORTHO	712.92	CRYST ARTHROP NOS—UP/AR

TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
ORTHO	712.93	CRYS ARTHROP NOS—FOREAR
ORTHO	712.94	CRYST ARTHROP NOS—HAND
ORTHO	712.95	CRYST ARTHROP NOS—PELVI
ORTHO	712.96	CRYST ARTHROP NOS—L/LEG
ORTHO	712.97	CRYST ARTHROP NOS—ANKLE
ORTHO	712.98	CRY ARTHROP NOS—OTH SIT
ORTHO	712.99	CRYST ARTHROP NOS—MULT
ORTHO	714	OTH INFLAMM POLYARTHROP
ORTHO	716	ARTHROPATHIES NEC/NOS
ORTHO	717	INTERNAL DERANGEMNT KNEE
ORTHO	718	OTHER JOINT DERANGEMENT
ORTHO	720.0	ANKYLOSING SPONDYLITIS
ORTHO	720.1	SPINAL ENTHESOPATHY
ORTHO	720.2	SACROILIITIS NEC
ORTHO	720.89	INFLAM SPONDYLOPATHY NEC
ORTHO	720.9	INFLAM SPONDYLOPATHY NOS
ORTHO	721	SPONDYLOSIS ET AL
ORTHO	722	INTERVERTEBRAL DISC DIS
ORTHO	723	OTHER CERVICAL SPINE DIS
ORTHO	724	BACK DISORDER NEC & NOS
ORTHO	725	POLYMYALGIA RHEUMATICA
ORTHO	728	DIS OF MUSCLE/LIG/FASCIA
ORTHO	730.00	AC OSTEOMYELITIS—UNSP
ORTHO	730.01	AC OSTEOMYELITIS—SHLDER
ORTHO	730.02	AC OSTEOMYELITIS—UP/ARM
ORTHO	730.03	AC OSTEOMYELITIS—FOREAR
ORTHO	730.04	AC OSTEOMYELITIS—HAND
ORTHO	730.05	AC OSTEOMYELITIS—PELVIS
ORTHO	730.06	AC OSTEOMYELITIS—L/LEG
ORTHO	730.07	AC OSTEOMYELITIS—ANKLE
ORTHO	730.08	AC OSTEOMYELITIS NEC
ORTHO	730.09	AC OSTEOMYELITIS—MULT
ORTHO	730.10	CHR OSTEOMYELITIS—UNSP
ORTHO	730.11	CHR OSTEOMYELIT—SHLDER
ORTHO	730.12	CHR OSTEOMYELIT—UP/ARM
ORTHO	730.13	CHR OSTEOMYELIT—FOREARM
ORTHO	730.14	CHR OSTEOMYELIT—HAND
ORTHO	730.15	CHR OSTEOMYELIT—PELVIS
ORTHO	730.16	CHR OSTEOMYELIT—L/LEG
ORTHO	730.17	CHR OSTEOMYELIT—ANKLE
ORTHO	730.18	CHR OSTEOMYELIT NEC
ORTHO	730.19	CHR OSTEOMYELIT—MULT
ORTHO	730.20	OSTEOMYELITIS NOS—UNSPE
ORTHO	730.21	OSTEOMYELITIS NOS—SHLDE
ORTHO	730.22	OSTEOMYELITIS NOS—UP/AR
ORTHO	730.23	OSTEOMYELIT NOS—FOREARM
ORTHO	730.24	OSTEOMYELITIS NOS—HAND
ORTHO	730.25	OSTEOMYELITIS NOS—PELVI
ORTHO	730.26	OSTEOMYELITIS NOS—L/LEG
ORTHO	730.27	OSTEOMYELITIS NOS—ANKLE
ORTHO	730.28	OSTEOMYELIT NOS—OTH SIT
ORTHO	730.29	OSTEOMYELITIS NOS—MULT
ORTHO	730.30	PERIOSTITIS—UNSPEC
ORTHO	730.31	PERIOSTITIS—SHLDER
ORTHO	730.32	PERIOSTITIS—UP/ARM
ORTHO	730.33	PERIOSTITIS—FOREARM
ORTHO	730.34	PERIOSTITIS—HAND
ORTHO	730.35	PERIOSTITIS—PELVIS
ORTHO	730.36	PERIOSTITIS—L/LEG
ORTHO	730.37	PERIOSTITIS—ANKLE
ORTHO	730.38	PERIOSTITIS NEC
ORTHO	730.39	PERIOSTITIS—MULT
ORTHO	730.90	BONE INFEC NOS—UNSP SIT
ORTHO	730.91	BONE INFECT NOS—SHLDER
ORTHO	730.92	BONE INFECT NOS—UP/ARM
ORTHO	730.93	BONE INFECT NOS—FOREARM
ORTHO	730.94	BONE INFECT NOS—HAND
ORTHO	730.95	BONE INFECT NOS—PELVIS
ORTHO	730.96	BONE INFECT NOS—L/LEG
ORTHO	730.97	BONE INFECT NOS—ANKLE

TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
ORTHO	730.98	BONE INFECT NOS—OTH SIT
ORTHO	730.99	BONE INFECT NOS—MULT
ORTHO	731.0	OSTEITIS DEFORMANS NOS
ORTHO	731.2	HYPERTROPH OSTEOARTHROP
ORTHO	732	OSTEOCHONDROPATHIES
ORTHO	781	NERV/MUSCULSKEL SYS SYMP
ORTHO	800	SKULL VAULT FRACTURE
ORTHO	801	SKULL BASE FRACTURE
ORTHO	802	FRACTURE OF FACE BONES
ORTHO	803	OTHER SKULL FRACTURE
ORTHO	804	MULT FX SKULL W OTH BONE
ORTHO	805	VERTEBRL FX W/O CORD INJ
ORTHO	806	VERTEBRAL FX W CORD INJ
ORTHO	807	FX RIB/STERN/LARYN/TRACH
ORTHO	808	PELVIC FRACTURE
ORTHO	809	FRACTURE OF TRUNK BONES
ORTHO	810	CLAVICLE FRACTURE
ORTHO	811	SCAPULA FRACTURE
ORTHO	812	HUMERUS FRACTURE
ORTHO	813	RADIUS & ULNA FRACTURE
ORTHO	814	CARPAL FRACTURE
ORTHO	815	METACARPAL FRACTURE
ORTHO	816	FRACTURE PHALANGES, HAND
ORTHO	817	MULTIPLE HAND FRACTURES
ORTHO	818	FRACTURE ARM MULT/NOS
ORTHO	819	FX ARMS W RIB/STERNUM
ORTHO	820	FRACTURE NECK OF FEMUR
ORTHO	821	OTHER FEMORAL FRACTURE
ORTHO	822	PATELLA FRACTURE
ORTHO	823	TIBIA & FIBULA FRACTURE
ORTHO	824	ANKLE FRACTURE
ORTHO	825	FX OF TARSAL/METATARSAL
ORTHO	827	LOWER LIMB FRACTURE NEC
ORTHO	828	FX LEGS W ARM/RIB
ORTHO	831	SHOULDER DISLOCATION
ORTHO	832	ELBOW DISLOCATION
ORTHO	833	WRIST DISLOCATION
ORTHO	835	DISLOCATION OF HIP
ORTHO	836	DISLOCATION OF KNEE
ORTHO	837	DISLOCATION OF ANKLE
ORTHO	838	DISLOCATION OF FOOT
ORTHO	846	SPRAIN SACROILIAC REGION
ORTHO	847	SPRAIN OF BACK NEC/NOS
ORTHO	887	TRAUMATIC AMPUT ARM/HAND
ORTHO	896	TRAUMATIC AMPUTAT FOOT
ORTHO	897	TRAUMATIC AMPUTATION LEG
ORTHO	927	CRUSHING INJ UPPER LIMB
ORTHO	928	CRUSHING INJURY OF LEG

Secondary Diagnoses

The following diagnoses should never be used as primary diagnoses, according to ICD–9–CM coding guidelines. The case-mix system will recognize them in the clinical dimension if they appear as the first secondary diagnosis (line b, M0240 on the OASIS record). Diagnoses coded with 4 or 5 digits must be coded as shown to be recognized in the clinical dimension.

NEURO	320.7	MENINGITIS IN OTH BAC
NEURO	321.0	CRYPTOCOCCAL MENINGITIS
NEURO	321.1	MENING IN OTH FUNGAL DI
NEURO	321.2	MENING IN OTH VIRAL DIS
NEURO	321.3	TRYPANOSOMIASIS MENINGI
NEURO	321.4	MENINGIT D/T SARCOIDOSI
NEURO	321.8	MENING IN OTH NONBAC DI
NEURO	323.0	ENCEPHALIT IN VIRAL DIS
NEURO	323.1	RICKETTSIAL ENCEPHALITI
NEURO	323.2	PROTOZOAL ENCEPHALITIS
NEURO	323.4	OTH ENCEPHALIT D/T INFE
NEURO	323.6	POSTINFECT ENCEPHALITIS
NEURO	323.7	TOXIC ENCEPHALITIS
NEURO	330.2	CEREB DEGEN IN LIPIDOSI
NEURO	330.3	CERB DEG CHLD IN OTH DI

TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
NEURO	331.7	CEREB DEGEN IN OTH DIS
NEURO	334.4	CEREBEL ATAX IN OTH DIS
NEURO	336.2	COMB DEG CORD IN OTH DI
NEURO	336.3	MYELOPATHY IN OTH DIS
NEURO	337.1	AUT NEUROPTHY IN OTH DI
NEURO	357.1	NEURPTHY IN COL VASC DI
NEURO	357.2	NEUROPATHY IN DIABETES
NEURO	357.3	NEUROPATHY IN MALIG DIS
NEURO	357.4	NEUROPATHY IN OTHER DIS
NEURO	358.1	MYASTHENIA IN OTH DIS
ORTHO	711.10	REITER ARTHRITIS—UNSPEC
ORTHO	711.11	REITER ARTHRITIS—SHLDER
ORTHO	711.12	REITER ARTHRITIS—UP/ARM
ORTHO	711.13	REITER ARTHRITIS—FOREAR
ORTHO	711.14	REITER ARTHRITIS—HAND
ORTHO	711.15	REITER ARTHRITIS—PELVIS
ORTHO	711.16	REITER ARTHRITIS—L/LEG
ORTHO	711.17	REITER ARTHRITIS—ANKLE
ORTHO	711.18	REITER ARTHRITIS NEC
ORTHO	711.19	REITER ARTHRITIS—MULT
ORTHO	711.20	BEHCET ARTHRITIS—UNSPEC
ORTHO	711.21	BEHCET ARTHRITIS—SHLDER
ORTHO	711.22	BEHCET ARTHRITIS—UP/ARM
ORTHO	711.23	BEHCET ARTHRITIS—FOREAR
ORTHO	711.24	BEHCET ARTHRITIS—HAND
ORTHO	711.25	BEHCET ARTHRITIS—PELVIS
ORTHO	711.26	BEHCET ARTHRITIS—L/LEG
ORTHO	711.27	BEHCET ARTHRITIS—ANKLE
ORTHO	711.28	BEHCET ARTHRITIS NEC
ORTHO	711.29	BEHCET ARTHRITIS—MULT
ORTHO	711.30	DYSENTER ARTHRIT—UNSPEC
ORTHO	711.31	DYSENTER ARTHRIT—SHLDER
ORTHO	711.32	DYSENTER ARTHRIT—UP/ARM
ORTHO	711.33	DYSENTER ARTHRIT—FOREAR
ORTHO	711.34	DYSENTER ARTHRIT—HAND
ORTHO	711.35	DYSENTER ARTHRIT—PELVIS
ORTHO	711.36	DYSENTER ARTHRIT—L/LEG
ORTHO	711.37	DYSENTER ARTHRIT—ANKLE
ORTHO	711.38	DYSENTER ARTHRIT NEC
ORTHO	711.39	DYSENTER ARTHRIT—MULT
ORTHO	711.40	BACT ARTHRITIS—UNSPEC
ORTHO	711.41	BACT ARTHRITIS—SHLDER
ORTHO	711.42	BACT ARTHRITIS—UP/ARM
ORTHO	711.43	BACT ARTHRITIS—FOREARM
ORTHO	711.44	BACT ARTHRITIS—HAND
ORTHO	711.45	BACT ARTHRITIS—PELVIS
ORTHO	711.46	BACT ARTHRITIS—L/LEG
ORTHO	711.47	BACT ARTHRITIS—ANKLE
ORTHO	711.48	BACT ARTHRITIS NEC
ORTHO	711.49	BACT ARTHRITIS—MULT
ORTHO	711.50	VIRAL ARTHRITIS—UNSPEC
ORTHO	711.51	VIRAL ARTHRITIS—SHLDER
ORTHO	711.52	VIRAL ARTHRITIS—UP/ARM
ORTHO	711.53	VIRAL ARTHRITIS—FOREARM
ORTHO	711.54	VIRAL ARTHRITIS—HAND
ORTHO	711.55	VIRAL ARTHRITIS—PELVIS
ORTHO	711.56	VIRAL ARTHRITIS—L/LEG
ORTHO	711.57	VIRAL ARTHRITIS—ANKLE
ORTHO	711.58	VIRAL ARTHRITIS NEC
ORTHO	711.59	VIRAL ARTHRITIS—MULT
ORTHO	711.60	MYCOTIC ARTHRITIS—UNSPE
ORTHO	711.61	MYCOTIC ARTHRITIS—SHLDE
ORTHO	711.62	MYCOTIC ARTHRITIS—UP/AR
ORTHO	711.63	MYCOTIC ARTHRIT—FOREARM
ORTHO	711.64	MYCOTIC ARTHRITIS—HAND
ORTHO	711.65	MYCOTIC ARTHRITIS—PELVI
ORTHO	711.66	MYCOTIC ARTHRITIS—L/LEG
ORTHO	711.67	MYCOTIC ARTHRITIS—ANKLE
ORTHO	711.68	MYCOTIC ARTHRITIS NEC
ORTHO	711.69	MYCOTIC ARTHRITIS—MULT

TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
ORTHO	711.70	HELMINTH ARTHRIT—UNSPEC
ORTHO	711.71	HELMINTH ARTHRIT—SHLDER
ORTHO	711.72	HELMINTH ARTHRIT—UP/ARM
ORTHO	711.73	HELMINTH ARTHRIT—FOREAR
ORTHO	711.74	HELMINTH ARTHRIT—HAND
ORTHO	711.75	HELMINTH ARTHRIT—PELVIS
ORTHO	711.76	HELMINTH ARTHRIT—L/LEG
ORTHO	711.77	HELMINTH ARTHRIT—ANKLE
ORTHO	711.78	HELMINTH ARTHRIT NEC
ORTHO	711.79	HELMINTH ARTHRIT—MULT
ORTHO	711.80	INF ARTHRITIS NEC—UNSPE
ORTHO	711.81	INF ARTHRITIS NEC—SHLDE
ORTHO	711.82	INF ARTHRITIS NEC—UP/AR
ORTHO	711.83	INF ARTHRIT NEC—FOREARM
ORTHO	711.84	INF ARTHRITIS NEC—HAND
ORTHO	711.85	INF ARTHRITIS NEC—PELVI
ORTHO	711.86	INF ARTHRITIS NEC—L/LEG
ORTHO	711.87	INF ARTHRITIS NEC—ANKLE
ORTHO	711.88	INF ARTHRIT NEC—OTH SIT
ORTHO	711.89	INF ARTHRITIS NEC—MULT
ORTHO	712.10	DICALC PHOS CRYST—UNSPE
ORTHO	712.11	DICALC PHOS CRYST—SHLDE
ORTHO	712.12	DICALC PHOS CRYST—UP/AR
ORTHO	712.13	DICALC PHOS CRYS—FOREAR
ORTHO	712.14	DICALC PHOS CRYST—HAND
ORTHO	712.15	DICALC PHOS CRYST—PELVI
ORTHO	712.16	DICALC PHOS CRYST—L/LEG
ORTHO	712.17	DICALC PHOS CRYST—ANKLE
ORTHO	712.18	DICALC PHOS CRY—SITE NE
ORTHO	712.19	DICALC PHOS CRYST—MULT
ORTHO	712.20	PYROPHOSPH CRYST—UNSPEC
ORTHO	712.21	PYROPHOSPH CRYST—SHLDER
ORTHO	712.22	PYROPHOSPH CRYST—UP/ARM
ORTHO	712.23	PYROPHOSPH CRYST—FOREAR
ORTHO	712.24	PYROPHOSPH CRYST—HAND
ORTHO	712.25	PYROPHOSPH CRYST—PELVIS
ORTHO	712.26	PYROPHOSPH CRYST—L/LEG
ORTHO	712.27	PYROPHOSPH CRYST—ANKLE
ORTHO	712.28	PYROPHOS CRYST—SITE NEC
ORTHO	712.29	PYROPHOS CRYST—MULT
ORTHO	712.30	CHONDROCALCIN NOS—UNSPE
ORTHO	712.31	CHONDROCALCIN NOS—SHLDE
ORTHO	712.32	CHONDROCALCIN NOS—UP/AR
ORTHO	712.33	CHONDROCALC NOS—FOREARM
ORTHO	712.34	CHONDROCALCIN NOS—HAND
ORTHO	712.35	CHONDROCALCIN NOS—PELVI
ORTHO	712.36	CHONDROCALCIN NOS—L/LEG
ORTHO	712.37	CHONDROCALCIN NOS—ANKLE
ORTHO	712.38	CHONDROCALC NOS—OTH SIT
ORTHO	712.39	CHONDROCALCIN NOS—MULT
ORTHO	713.0	ARTHROP W ENDOCR/MET DI
ORTHO	713.1	ARTHROP W NONINF GI DIS
ORTHO	713.2	ARTHROPATH W HEMATOL DI
ORTHO	713.3	ARTHROPATHY W SKIN DIS
ORTHO	713.4	ARTHROPATHY W RESP DIS
ORTHO	713.5	ARTHROPATHY W NERVE DIS
ORTHO	713.6	ARTHROP W HYPERSEN REAC
ORTHO	713.7	ARTHROP W SYSTEM DIS NE
ORTHO	713.8	ARTHROP W OTH DIS NEC
ORTHO	720.81	SPONDYLOPATHY IN OTH DI
ORTHO	730.70	POLIO OSTEOPATHY—UNSPEC
ORTHO	730.71	POLIO OSTEOPATHY—SHLDER
ORTHO	730.72	POLIO OSTEOPATHY—UP/ARM
ORTHO	730.73	POLIO OSTEOPATHY—FOREAR
ORTHO	730.74	POLIO OSTEOPATHY—HAND
ORTHO	730.75	POLIO OSTEOPATHY—PELVIS
ORTHO	730.76	POLIO OSTEOPATHY—L/LEG
ORTHO	730.77	POLIO OSTEOPATHY—ANKLE
ORTHO	730.78	POLIO OSTEOPATHY NEC
ORTHO	730.79	POLIO OSTEOPATHY—MULT

TABLE 8A.—DIAGNOSIS GROUPS IN THE CLINICAL DIMENSION—Continued

[**Note:** Codes shown at the 3-digit level include all the related 4- and 5-digit codes. Diagnoses coded with 4 or 5 digits must be coded as shown to receive a score in the clinical dimension.]

Diagnosis group	ICD–9–CM Code	Description
ORTHO	730.80	BONE INFECT NEC—UNSPEC
ORTHO	730.81	BONE INFECT NEC—SHLDER
ORTHO	730.82	BONE INFECT NEC—UP/ARM
ORTHO	730.83	BONE INFECT NEC—FOREARM
ORTHO	730.84	BONE INFECT NEC—HAND
ORTHO	730.85	BONE INFECT NEC—PELVIS
ORTHO	730.86	BONE INFECT NEC—L/LEG
ORTHO	730.87	BONE INFECT NEC—ANKLE
ORTHO	730.88	BONE INFECT NEC—OTH SIT
ORTHO	730.89	BONE INFECT NEC—MULT
ORTHO	731.1	OSTEITIS DEF IN OTH DIS
ORTHO	731.8	BONE INVOLV IN OTH DIS

TABLE 8B.—BURNS AND TRAUMA DIAGNOSES

[**Note:** Codes shown at the 3-digit level include all of the related 4- and 5-digit codes. Burns and trauma diagnoses are included in the clinical dimension if the diagnosis is the primary diagnosis and if box 1 of the OASIS item M0440 is checked.]

ICD–9–CM code	Description
870	OCULAR ADNEXA OPEN WOUND
872	OPEN WOUND OF EAR
873	OTHER OPEN WOUND OF HEAD
874	OPEN WOUND OF NECK
875	OPEN WOUND OF CHEST
876	OPEN WOUND OF BACK
877	OPEN WOUND OF BUTTOCK
878	OPEN WOUND GENITAL ORGAN
879	OPEN WOUND SITE NEC
880	OPN WND SHOULDR/UPPR ARM
881	OPEN WOUND OF LOWER ARM
882	OPEN WOUND OF HAND
883	OPEN WOUND OF FINGER
884	OPEN WOUND ARM MULT/NOS
885	TRAUM AMPUTATION THUMB
886	TRAUM AMPUTATION FINGER
890	OPEN WOUND OF HIP/THIGH
891	OPEN WND KNEE/LEG/ANKLE
892	OPEN WOUND OF FOOT
893	OPEN WOUND OF TOE
894	OPEN WOUND OF LEG NEC
895	TRAUMATIC AMPUTATION TOE
941	BURN OF HEAD/FACE/NECK
942	BURN OF TRUNK
943	BURN OF ARM
944	BURN OF HAND & WRIST
945	BURN OF LEG
946	BURN OF MULTIPLE SITE
948	BURN BY % BODY SURFACE
949	BURN UNSPECIFIED

3. Determining the Case-Mix Indices

Calculation of the case-mix relative weights. We derived the relative weights for the case-mix groups from a straightforward multiple regression analysis. The data for the regression came from the Abt sample episodes with more than four visits (the same sample used to develop and validate the case-mix model).

The coefficients that resulted from the regression equation are shown below. The multiple regression coefficients are estimates of the average addition to resource cost due to each severity level above the lowest-severity case-mix group (C0F0S0). For each case-mix group, the average resource cost is calculated from the sum of the appropriate regression coefficients. In the example below, the average resource cost for case-mix group C3F0S3 is the sum of the average resource cost for the base group (C0F0S0) plus the average additional cost due to C3 plus the average additional cost due to S3. We then used the computed case-mix-group average resource costs to find the relative case-mix weights. Specifically, the case-mix group averages (that is, sum of appropriate regression coefficients) are divided by the overall average resource cost. The case-mix weights are shown in Table 9.

The methodology for calculating the case-mix weights is the same one we used to find the case-mix weights in the proposed rule, except that we did not use weighted regression for the final rule. We determined that the distribution of the unweighted Abt Associates data better resembled the 1998 episode file distribution than did the weighted Abt Associates data. Thus, unweighted regression was the appropriate methodology. As stated in the proposed rule, we plan to refine the case-mix weights to adjust for changes in patient population, actual changes in home health care practice patterns, and changes in the coding or classification of patients that do not reflect real changes in case-mix.

Regression Coefficients for Calculating Case-Mix Relative Weights

Intercept*—$1,271.95
C1—$230.98
C2—$652.42
C3—$1,620.75
F1—$229.14
F2—$479.30
F3—$571.20
F4—$976.08
S1—$195.53
S2—$2,315.15
S3—$2,923.22

Example:

Calculate case-mix relative weight for group C3F0S3

Overall average resource cost (scaled to national average episode cost): $2,416.00

Relative weight = average resource cost for group C3F0S3 divided by overall average resource cost = (base group cost +C3 increment +S3 increment)/overall average resource cost = (1271.95 + 1620.75 + 2923.22)/2416.00 = 2.4073

Below we show the average resource cost calculated from the regression coefficients for each case-mix group.

Regression coefficient	Average resource cost
C0F0S0	$1,271.95
C0F0S1	1,467.48
C0F0S2	3,587.10
C0F0S3	4,195.17
C0F1S0	1,501.09
C0F1S1	1,696.62
C0F1S2	3,816.24
C0F1S3	4,424.31
C0F2S0	1,751.25
C0F2S1	1,946.77
C0F2S2	4,066.40
C0F2S3	4,674.46
C0F3S0	1,843.15
C0F3S1	2,038.68
C0F3S2	4,158.30

* Intercept value is the average resource cost for the base group, C0F0S0.

Regression coefficient	Average resource cost
C0F3S3	4,766.37
C0F4S0	2,248.03
C0F4S1	2,443.56
C0F4S2	4,563.18
C0F4S3	5,171.25
C1F0S0	1,502.93
C1F0S1	1,698.46
C1F0S2	3,818.08
C1F0S3	4,426.15
C1F1S0	1,732.07
C1F1S1	1,927.60
C1F1S2	4,047.22
C1F1S3	4,655.29
C1F2S0	1,982.23
C1F2S1	2,177.75
C1F2S2	4,297.38
C1F2S3	4,905.45
C1F3S0	2,074.13
C1F3S1	2,269.66
C1F3S2	4,389.28
C1F3S3	4,997.35
C1F4S0	2,479.01
C1F4S1	2,674.54
C1F4S2	4,794.16
C1F4S3	5,402.23
C2F0S0	1,924.37
C2F0S1	2,119.90
C2F0S2	4,239.52
C2F0S3	4,847.59
C2F1S0	2,153.51
C2F1S1	2,349.04
C2F1S2	4,468.66
C2F1S3	5,076.73
C2F2S0	2,403.67
C2F2S1	2,599.19
C2F2S2	4,718.82
C2F2S3	5,326.89
C2F3S0	2,495.57
C2F3S1	2,691.10
C2F3S2	4,810.72
C2F3S3	5,418.79
C2F4S0	2,900.45
C2F4S1	3,095.98
C2F4S2	5,215.61
C2F4S3	5,823.67
C3F0S0	2,892.70
C3F0S1	3,088.23
C3F0S2	5,207.85
C3F0S3	5,815.92
C3F1S0	3,121.84
C3F1S1	3,317.37
C3F1S2	5,436.99
C3F1S3	6,045.06
C3F2S0	3,372.00
C3F2S1	3,567.52
C3F2S2	5,687.15
C3F2S3	6,295.22
C3F3S0	3,463.91
C3F3S1	3,659.43
C3F3S2	5,779.06
C3F3S3	6,387.12
C3F4S0	3,868.79
C3F4S1	4,064.31
C3F4S2	6,183.94
C3F4S3	6,792.00

Construction of the Relative Weights for the HHRGs

TABLE 9.—RELATIVE CASE-MIX WEIGHTS CORRESPONDING TO HOME HEALTH RESOURCE GROUPS

HHRG group	HHRG description	Case-mix weight
C0F0S0	''Clinical=Min, Functional=Min, Service=Min''	0.5265
C0F0S1	''Clinical=Min, Functional=Min, Service=Low''	0.6074
C0F0S2	''Clinical=Min, Functional=Min, Service=Mod''	1.4847
C0F0S3	''Clinical=Min, Functional=Min, Service=High''	1.7364
C0F1S0	''Clinical=Min, Functional=Low, Service=Min''	0.6213
C0F1S1	''Clinical=Min, Functional=Low, Service=Low''	0.7022
C0F1S2	''Clinical=Min, Functional=Low, Service=Mod''	1.5796
C0F1S3	''Clinical=Min, Functional=Low, Service=High''	1.8313
C0F2S0	''Clinical=Min, Functional=Mod, Service=Min''	0.7249
C0F2S1	''Clinical=Min, Functional=Mod, Service=Low''	0.8058
C0F2S2	''Clinical=Min, Functional=Mod, Service=Mod''	1.6831
C0F2S3	''Clinical=Min, Functional=Mod, Service=High''	1.9348
C0F3S0	''Clinical=Min, Functional=High, Service=Min''	0.7629
C0F3S1	''Clinical=Min, Functional=High, Service=Low''	0.8438
C0F3S2	''Clinical=Min, Functional=High, Service=Mod''	1.7212
C0F3S3	''Clinical=Min, Functional=High, Service=High''	1.9728
C0F4S0	''Clinical=Min, Functional=Max, Service=Min''	0.9305
C0F4S1	''Clinical=Min, Functional=Max, Service=Low''	1.0114
C0F4S2	''Clinical=Min, Functional=Max, Service=Mod''	1.8887
C0F4S3	''Clinical=Min, Functional=Max, Service=High''	2.1404
C1F0S0	''Clinical=Low, Functional=Min, Service=Min''	0.6221
C1F0S1	''Clinical=Low, Functional=Min, Service=Low''	0.7030
C1F0S2	''Clinical=Low, Functional=Min, Service=Mod''	1.5803
C1F0S3	''Clinical=Low, Functional=Min, Service=High''	1.8320
C1F1S0	''Clinical=Low, Functional=Low, Service=Min''	0.7169
C1F1S1	''Clinical=Low, Functional=Low, Service=Low''	0.7978
C1F1S2	''Clinical=Low, Functional=Low, Service=Mod''	1.6752
C1F1S3	''Clinical=Low, Functional=Low, Service=High''	1.9269
C1F2S0	''Clinical=Low, Functional=Mod, Service=Min''	0.8205
C1F2S1	''Clinical=Low, Functional=Mod, Service=Low''	0.9014
C1F2S2	''Clinical=Low, Functional=Mod, Service=Mod''	1.7787
C1F2S3	''Clinical=Low, Functional=Mod, Service=High''	2.0304
C1F3S0	''Clinical=Low, Functional=High, Service=Min''	0.8585
C1F3S1	''Clinical=Low, Functional=High, Service=Low''	0.9394
C1F3S2	''Clinical=Low, Functional=High, Service=Mod''	1.8168
C1F3S3	''Clinical=Low, Functional=High, Service=High''	2.0684
C1F4S0	''Clinical=Low, Functional=Max, Service=Min''	1.0261
C1F4S1	''Clinical=Low, Functional=Max, Service=Low''	1.1070
C1F4S2	''Clinical=Low, Functional=Max, Service=Mod''	1.9843
C1F4S3	''Clinical=Low, Functional=Max, Service=High''	2.2360
C2F0S0	''Clinical=Mod, Functional=Min, Service=Min''	0.7965
C2F0S1	''Clinical=Mod, Functional=Min, Service=Low''	0.8774
C2F0S2	''Clinical=Mod, Functional=Min, Service=Mod''	1.7548
C2F0S3	''Clinical=Mod, Functional=Min, Service=High''	2.0065
C2F1S0	''Clinical=Mod, Functional=Low, Service=Min''	0.8914

TABLE 9.—RELATIVE CASE-MIX WEIGHTS CORRESPONDING TO HOME HEALTH RESOURCE GROUPS—Continued

HHRG group	HHRG description	Case-mix weight
C2F1S1	''Clinical=Mod, Functional=Low, Service=Low''	0.9723
C2F1S2	''Clinical=Mod, Functional=Low, Service=Mod''	1.8496
C2F1S3	''Clinical=Mod, Functional=Low, Service=High''	2.1013
C2F2S0	''Clinical=Mod, Functional=Mod, Service=Min''	0.9949
C2F2S1	''Clinical=Mod, Functional=Mod, Service=Low''	1.0758
C2F2S2	''Clinical=Mod, Functional=Mod, Service=Mod''	1.9532
C2F2S3	''Clinical=Mod, Functional=Mod, Service=High''	2.2048
C2F3S0	''Clinical=Mod, Functional=High, Service=Min''	1.0329
C2F3S1	''Clinical=Mod, Functional=High, Service=Low''	1.1139
C2F3S2	''Clinical=Mod, Functional=High, Service=Mod''	1.9912
C2F3S3	''Clinical=Mod, Functional=High, Service=High''	2.2429
C2F4S0	''Clinical=Mod, Functional=Max, Service=Min''	1.2005
C2F4S1	''Clinical=Mod, Functional=Max, Service=Low''	1.2814
C2F4S2	''Clinical=Mod, Functional=Max, Service=Mod''	2.1588
C2F4S3	''Clinical=Mod, Functional=Max, Service=High''	2.4105
C3F0S0	''Clinical=High, Functional=Min, Service=Min''	1.1973
C3F0S1	''Clinical=High, Functional=Min, Service=Low''	1.2782
C3F0S2	''Clinical=High, Functional=Min, Service=Mod''	2.1556
C3F0S3	''Clinical=High, Functional=Min, Service=High''	2.4073
C3F1S0	''Clinical=High, Functional=Low, Service=Min''	1.2922
C3F1S1	''Clinical=High, Functional=Low, Service=Low''	1.3731
C3F1S2	''Clinical=High, Functional=Low, Service=Mod''	2.2504
C3F1S3	''Clinical=High, Functional=Low, Service=High''	2.5021
C3F2S0	''Clinical=High, Functional=Mod, Service=Min''	1.3957
C3F2S1	''Clinical=High, Functional=Mod, Service=Low''	1.4766
C3F2S2	''Clinical=High, Functional=Mod, Service=Mod''	2.3540
C3F2S3	''Clinical=High, Functional=Mod, Service=High''	2.6056
C3F3S0	''Clinical=High, Functional=High, Service=Min''	1.4337
C3F3S1	''Clinical=High, Functional=High, Service=Low''	1.5147
C3F3S2	''Clinical=High, Functional=High, Service=Mod''	2.3920
C3F3S3	''Clinical=High, Functional=High, Service=High''	2.6437
C3F4S0	''Clinical=High, Functional=Max, Service=Min''	1.6013
C3F4S1	''Clinical=High, Functional=Max, Service=Low''	1.6822
C3F4S2	''Clinical=High, Functional=Max, Service=Mod''	2.5596
C3F4S3	''Clinical=High, Functional=Max, Service=High''	2.8113

H. Consolidated Billing

1. Background

Under the HHA consolidated billing requirement established by sections 4603(c)(2)(B) and (c)(2)(C) of the BBA, the HHA that establishes the home health plan of care has the Medicare billing responsibility for all of the Medicare-covered home health services listed in section 1861(m) of the Act that the patient receives and are ordered by the physician in the plan of care. Section 305 of BBRA of 1999 amended the consolidated billing language governing home health PPS by eliminating DME covered as a home health service from the consolidated billing requirements.

2. HHA Consolidated Billing Legislation

Specific Provisions of the Legislation. Sections 4603(c)(2)(B) and (c)(2)(C) of the BBA amend sections 1842(b)(6) and 1862(a) of the Act, respectively, to require a new consolidated billing and bundling of all home health services while a beneficiary is under the plan of care. The statute now requires payment for all items and services to be made to an agency. As stated above, section 305 of BBRA of 1999 excludes DME covered as a home health service from the consolidated billing requirements.

Specifically, the law requires, ''in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under the plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''

Moreover, there will be separate payment for DME items and services provided under the home health benefit, which are under the DME fee schedule. As discussed previously, under the HHA PPS, DME covered as a home health service as part of the Medicare home health benefit will continue to be paid under the DME fee schedule and will also be excluded from the consolidated billing requirements. In addition to the prospective payment amount for home health services a separate payment amount will be made for DME currently covered as a home health service under the PPS.

3. Types of Services That Are Subject to the Provision

Under the consolidated billing requirement, we require that the HHA must submit all Medicare claims for all home health services included in section 1861(m) of the Act (including medical supplies described in section 1861(m)(5)) of the Act, but excluding DME to the extent provided for in such section), while the beneficiary is under the home health plan of care established by a physician and eligible for the home health benefit. The home health services included in consolidated billing are:

- Part-time or intermittent skilled nursing care.
- Part-time or intermittent home health aide services.
- Physical therapy.
- Speech-language pathology.
- Occupational therapy, medical social services.

• Routine and nonroutine medical supplies.
• A covered osteoporosis drug (as defined in section 1861(kk) of the Act-(not paid under PPS rate, see 1833(a)(2)(A)), but excluding other drugs and biologicals).
• Medical services provided by an intern or resident- in-training of the hospital, under an approved teaching program of the hospital in the case of an HHA that is affiliated or under common control with a hospital.
• Services at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

4. Effects of This Provision

HHAs will no longer be able to ''unbundle'' services to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the HHA itself will have to furnish the home health services (except DME) either directly or under an arrangement with an outside supplier in which the HHA itself, rather than the supplier, bills Medicare. With the exception of DME, the outside supplier must look to the HHA rather than to Medicare Part B for payment. Beneficiaries receiving DME prior to establishment of a home health plan of care, can continue the relationship with that same DME supplier. The consolidated billing requirement eliminates the potential for duplicative billings for the same services to the RHHI by the HHA and to the Part B carrier by an outside supplier. All covered home health services listed in section 1861(m) of the Act, (including medical supplies described in section 1861(m)(5) of the Act, but excluding DME to the extent provided in such section) ordered in the patient's plan of care must be billed by the HHA.

As discussed in the proposed rule published on October 28, 1999, the responsibility for consolidated billing moves to the transfer HHA. The consolidated billing requirement enhances the HHA's capacity to meet its existing responsibility to oversee and coordinate the Medicare- covered home health services that each of its patients receives.

Consistent with SNF PPS consolidated billing, the beneficiary exercises his or her freedom of choice for the entire home health benefit of services listed in section 1861(m) of the Act, including medical supplies described in section 1861(m)(5) of the Act, but excluding DME as a home health service by choosing the HHA. Once a home health patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the home health benefit during the certified episode.

Current law is silent regarding the specific terms of an HHA's payment to an outside supplier, and does not authorize the Medicare program to impose any requirements in this regard. We remain concerned, however, over the potential for the provision of unnecessary services, and will continue to evaluate approaches addressing this concern. One appropriate way to address any abusive practices would be through more vigorous enforcement of existing statutes and regulations (such as medical review procedures). Furthermore, since under current law, an HHA's relationship with its supplier is essentially a private contractual matter, the terms of the supplier's payment by the HHA must be arrived through direct negotiations between the two parties themselves. Accordingly, we believe that the most effective way for a supplier to address any concerns that it may have about the adequacy or timeliness of the HHA's payment would be for the supplier to ensure that any terms to which it agrees in such negotiations satisfactorily address those concerns. Finally, we note that matters relating to the enforcement of the statutory anti-kickback provisions lie exclusively within the purview of the Office of the Inspector General, and any questions or concerns in this area should be directed to the attention of that agency.

5. Effective Date for Consolidated Billing

The effective date for consolidated billing is October 1, 2000.

V. Provisions of the Final Rule

We are adopting the provisions of the proposed rule with the following revisions:

Section 409.43

We revised paragraph (c) to clarify that the request for anticipated payment for the initial percentage payment is not a Medicare claim under the Act and subject to the requirement that the physician sign the plan of care before the HHA bills for the initial percentage payment. The request for anticipated payment for the initial percentage episode payment may be based on verbal orders that are copied into the plan of care with the plan of care being immediately submitted to the physician. However, the requests for anticipated payments may be modified or withheld in order to protect Medicare program integrity. However, the final percentage payment is a claim subject to the current physician signature requirements. We revised current paragraph (c) governing physician signature of the plan of care. Specifically, paragraph (c)(1) of this section specifies, ''If the physician signed plan of care is not available, the request for anticipated payment of the initial percentage payment must be based on—

• A physician's verbal order that—
++ Is recorded in the plan of care;
++ Includes a description of the patient's condition and the services to be provided by the home health agency;
++ Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care; and
++ Is copied into the plan of care and the plan of care is immediately submitted to the physician; or
• A referral prescribing detailed orders for the services to be provided that is signed and dated by a physician.''

In paragraph (c)(2) of this section, we specify that ''HCFA has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal orders as specified in paragraphs (c)(1)(i) and/or a prescribing referral as specified in (c)(1)(ii) of this section and is not a Medicare claim for purposes of the Act (although it is a ''claim'' for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the Civil Monetary Penalties Law (as defined in 42 U.S.C. 1320a–7a (i) (2)), the Civil False Claims Act (as defined in 31 U.S.C. 3729(c)), and the Criminal False Claims Act (18 U.S.C. 287)), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.''

Paragraph (c)(3) of this section specifies that ''The plan of care must be signed and dated—

• By a physician as described who meets the certification and recertification requirements of § 424.22 of this chapter and;

• Before the claim for each episode for services is submitted for the final percentage payment.''

Paragraph (c)(4) of this section specifies that ''Any changes in the plan must be signed and dated by a physician.''

Section 409.43

We revised the paragraph (e) of this section to clarify that the plan of care must be reviewed by the physician at least every 60 days or more frequently when there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the same 60-day episode.

We also made a conforming change in paragraph (f) of this section regarding the termination of the plan of care by replacing ''62-day'' with ''60-day.'' We amended this paragraph to specify that if specific services are not provided to the beneficiary at least once every 60-days, the plan of care is terminated unless the physician documents that the interval without this care is appropriate to the treatment of the beneficiary's condition.

Sections 409.100(a)(2), 410.150(b)(19), and 411.15(q)

We revised the regulations at §§ 409.100(a)(2), 410.150(b)(19), and 411.15(q) to conform to the BBRA revisions that eliminate DME from the consolidated billing requirements.

Section 413.64

We revised § 413.1(h) to clarify that durable medical equipment and the covered osteoporosis drug as defined in section 1861(m) of the Act are not included in the HHA PPS rate.

We deleted § 413.64(h)(2)(iv). This corresponds to our revision in the proposed rule to remove Part A and Part B home health services from § 413.64(h)(1). PIP is eliminated for home health services upon implementation of PPS.

Section 424.22

We are not adopting proposed paragraph (a)(1)(v) that would have required the physician to certify the correct HHRG.

Section 484.1(a)

We amended this section by adding a new paragraph (3) to include the provision under the Act that provides the basis for establishing the new prospective payment system for home health services covered under Medicare.

Section 484.18

We revised the paragraph (b) to clarify that the plan of care must be reviewed by the physician at least every 60 days or more frequently when there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the same 60-day episode.

Section 484.55

We revised paragraph (d)(1) to specify that the update to the comprehensive assessment is required the last five days of every 60 days beginning with the start of care date unless there is an applicable payment adjustment. This clarification parallels the current OASIS requirements governing the timeframe of the update.

Section 484.202

We amended this section by removing the term ''clinical model'' from the list of definitions because we did not use the term in this subpart.

Section 484.205

We revised paragraph (a)(1) and (b) to clarify that the PPS payments are based on a predetermined rate for a home health service previously paid on a reasonable cost basis and that the osteoporosis drug covered under the home health benefit is the only home health service listed in section 1861(m) of the Act that continues to be paid on a reasonable cost basis under PPS. The revised language will read, ''The national 60-day episode payment represents payment in full for all costs associated with furnishing a home health service paid on a reasonable cost basis (except the osteoporosis drug listed in section 1861(m) of the Act as defined in section 1861(kk) of the Act) as of August 5, 1997 * * *''

We also clarify in paragraph (b) that all payments under this system must be subject to a medical review adjustment reflecting beneficiary eligibility, medical necessity determinations, and the HHRG assignment.

We added paragraphs (b)(1) and (b)(2) that provides for the requirements governing the final split percentage payment approach. New paragraph (b)(1) governs the split percentage payment approach for initial episodes. The initial percentage payment for initial episodes is paid at 60 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60 day episode rate. New paragraph (b)(2) governs the split percentage payment approach for subsequent episodes. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate.

We revised paragraph (d) of this section to clarify that PEP adjustments do not apply in situations of transfer among HHAs of common ownership as defined in § 424.22. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA. The transferring HHA in situations of transfers among HHAs of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided for under arrangements to be paid.

Section 484.215

We renamed the heading of section 484.215 to clarify that the calculation reflects the initial establishment of the PPS rates. Section 484.215 has been revised to read ''Initial establishment of the calculation of the national 60-day episode payment.'' We revised paragraph (d)(4) to reflect the amounts that are added to the nonstandardized episode amount for the OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to PPS implementation.

Section 424.220

We revised § 484.220 to specify that HCFA adjusts the national 60-day episode payment rate to account for geographic differences in wage levels using an appropriate wage index based on the site of the service for the beneficiary.

Section 484.225(c)

We revised paragraph (c) to reflect that for each of FYs 2002 *and* 2003 the rates are updated by the applicable home health market basket minus 1.1 percentage points.

Section 484.230

We revised the language in this section to reflect the higher per-visit amounts that will be used to calculate the LUPA payments. The amounts will be referred to as national per-visit amounts. We also clarified that the wage

index are based on the site of service for the beneficiary.

Section 484.235

We revised paragraph (b) to reflect the use of billable visit dates as the defining points for the PEP adjustment. The following phrase will be added to the end of the sentence, ''* * * based on the first billable visit date through and including the last billable visit date.''

Section 484.237

We revised paragraphs (b)(1) and (b)(2) governing the SCIC adjustment to reflect the use of billable visit dates to define the span of days used to calculate the proportional payments both before and after a patient experiences a significant change in condition. In §§ 484.237(b)(1) and (b)(2) we inserted the phrase ''(the first billable visit date through and including the last billable visit date)'' after the phrase ''span of days.''

Section 484.240

We revised paragraph (d) to reflect the higher per- visit amounts that will be used to calculate the imputed costs for each episode for outlier payment determination. The amounts are referred to as national per-visit amounts.

Section 484.245

We added new § 484.245 that sets forth the processes involving accelerated payment requests by an HHA under PPS if there is a delay by the intermediary in making payment.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

However, the requirements summarized below are currently approved as indicated by the appropriate OMB control number.

Section 409.43 Plan of Care Requirements

Section 409.43(c) states that a plan of care must be signed and dated by a physician and meets the certification and recertification requirements of § 424.22 of this chapter, before the episode claim for services is submitted for the final percentage payment. This provision also states that any changes in the plan must be signed and dated by the physician. The requirements and burden associated with the plan of care are currently approved under OMB control numbers 0938–0357, with a current expiration date of 11/30/2000, 0938–0760 with a current expiration date of 09/30/2000, and 0938–0761 with a current expiration date of 09/30/2000.

Section 409.43(e) states that a plan of care must be reviewed, signed, and dated by the physician who reviews the plan of care (as specified in § 409.42(b))in consultation with agency professional personnel at least every 60 days. The requirements and burden associated with the plan of care are currently approved under OMB control numbers 0938–0357, with a current expiration date of 11/30/2000, 0938–0760 with a current expiration date of 09/30/2000, and 0938–0761 with a current expiration date of 09/30/2000.

Section 424.22 Requirements for Home Health Services

Section 424.22(b) states that a recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan of care. The requirements and burden associated with the plan of care are currently approved under OMB control numbers 0938–0357, with a current expiration date of 11/30/2000, 0938–0760 with a current expiration date of 09/30/2000, and 0938–0761 with a current expiration date of 09/30/2000.

Section 484.55 Comprehensive Assessment of Patients

Section 484.55 states that an HHA must update the comprehensive assessment by completing the appropriate OASIS schedule the last five days of every 60 days beginning with the start of care date unless there is a PEP adjustment or SCIC adjustment. The new requirement replaces the current language regarding ''every second calendar month'' with every 60 days.'' The requirements and burden associated with the plan of care are currently approved under OMB control numbers 0938–0357, with a current expiration date of 11/30/2000, 0938–0760 with a current expiration date of 09/30/2000, and 0938–0761 with a current expiration date of 09/30/2000.

Section 484.250 Patient Assessment Data.

Section 484.250 states that an HHA must submit OASIS data to HCFA as described at § 484.55(b)(1) and (d)(1) to administer the payment rate methodologies described in §§ 484.215, 484.230, 484.235, and 484.237. The requirements and burden associated with the plan of care are currently approved under OMB control numbers 0938–0357, with a current expiration date of 11/30/2000, 0938–0760 with a current expiration date of 09/30/2000, and 0938–0761 with a current expiration date of 09/30/2000.

VII. Regulatory Impact Analysis

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign based enterprises in domestic and export markets.

We estimate, based on a simulation model, that the redistributional effects on HHAs participating in the Medicare program associated with this final rule would range from a positive $428 million for freestanding not-for-profit agencies to a negative $363 million for freestanding for-profit agencies in FY 2001. Therefore, this rule, is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, (Public Law 104–4), and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for

major rules with economically significant effects ($100 million or more annually). Section 1895(b)(3)(A)(i) of the Act requires that the total amounts payable under the HHA PPS be equal to the total amount that would have been paid if this system had not been in effect. Section 302 of the BBRA amends section 1895(b)(3)(A)(ii) of the Act and delays the application of a 15 percent reduction in HHA PPS payment amounts until 1 year after its implementation. Section 306 of the BBRA amends section 1895(b)(3)(B)(ii) of the Act to require the standard prospective payment amounts to be increased by a factor equal to the home health market basket minus 1.1 percentage points for each of FYs 2002 and 2003. In addition, for subsequent fiscal years, the law requires the rates to be increased by the applicable home health market basket index change. Thus, subject to these adjustments, the statutory construction of this final rule is budget neutral. However, we are aware that there would be a number of organizational accommodations that must be made by HHAs in order to make the transition from the cost-based/interim payment system environment to a prospective payment environment that would result in costs to these entities. On that basis, we are preparing this RIA.

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in any given year. We believe that the costs associated with this final rule that apply to these governmental sectors would fall below this threshold. Therefore, the law does not apply and we have not prepared an assessment of anticipated costs and benefits of this final rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most HHAs are considered small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Table 10 illustrates the distribution of HHAs by provider type participating in Medicare as of March 16, 2000.

TABLE 10.—NUMBER OF HHAS BY PROVIDER TYPE

HHA Provider Type	Number of HHAs
Visiting Nurse Association	451
Combination of Government & Voluntary	35
Official Health Agency	910
Rehabilitation Facility Based	0
Hospital Based	2,278
Skilled Nursing Facility Based	161
Other	3,801
Total	7,636

Source: HCFA—On Line Survey Certification and Reporting System Standard Report 10—March 16, 2000.

The following RIA/RFA analysis, together with the rest of this preamble, explains the rationale for and purposes of this final rule.

A. Background

This final rule establishes requirements for the new prospective payment system for home health agencies as required by section 4603 of the Balanced Budget Act of 1997, as amended by section 5101 of OCESAA and sections 302, 305, and 306 of BBRA. The requirements include the implementation of a prospective payment system for home health agencies and a number of other related changes. The prospective payment system described in this rule would replace the retrospective reasonable cost-based system currently used by Medicare for the payment of home health services under Part A and Part B. This final rule sets forth a prospective payment system for all costs of home health services under section 1895 of the Act.

B. Revisions to the Proposed Rule

Below are listed a number of the significant changes to the proposed rule that are reflected in the final rule.

Section 409.100

Section 305 of the BBRA excludes DME covered as a home health service from the consolidated billing requirements. Specifically, the law requires, ''in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under the plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''

However, under HHA PPS there is a separate payment for DME items and services currently provided as a home health service and paid under the DME fee schedule. As discussed earlier, under the HHA PPS, DME covered as a home health service as part of the Medicare home health benefit will continue to be paid under the DME fee schedule. Further, in accordance with the statue, as amended by section 305 of BBRA, DME is also excluded from the consolidated billing requirements. A separate payment amount in addition to the prospective payment amount for home health services will be made for DME currently covered as a home health service under the PPS.

HHAs will no longer be able to ''unbundle'' home health services (other than DME) to an outside supplier that can then submit a separate bill directly to the Part B carrier or DMERC. Instead, the HHA itself will have to furnish the home health services (except DME) either directly or under an arrangement with an outside supplier in which the HHA itself, rather than the supplier, bills Medicare. The outside supplier must look to the HHA rather than to Medicare Part B for payment, except in the case of DME. Beneficiaries receiving DME prior to establishment of a home health plan of care can continue the relationship with that same DME supplier. The consolidated billing requirement eliminates the potential for duplicative billings for the same services to the RHHI by the HHA and to the Part B carrier by an outside supplier. All covered home health services listed in section 1861(m) (including medical supplies described in section 1861(m)(5), but excluding DME to the extent provided in such section) of the Act under a plan of care must be billed by the HHA.

Section 484.205

- We revised paragraph (a)(1) and (b) to clarify that the osteoporosis drug covered under the home health benefit is the only home health service listed in section 1861(m) of the Act that continues to be paid on a reasonable cost basis under PPS.
- We added paragraphs (b)(1) and (b)(2) that provides for the requirements governing the final split percentage payment approach. New paragraph (b)(1) governs the split percentage payment approach for initial episodes. The initial percentage payment for initial episodes is paid at 60 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for initial episodes is paid at 40 percent

of the case-mix and wage adjusted 60 day episode rate. New paragraph (b)(2) governs the split percentage payment approach for subsequent episodes. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate.

Section 484.215

We revised paragraph (d)(4) to reflect the amounts that are added to the nonstandardized episode amount for the OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to PPS implementation.

Section 484.225

We revised paragraph (c) to reflect that for each of FYs 2002 and 2003 the rates are updated by the applicable home health market basket minus 1.1 percentage points.

Section 484.230

We revised the language in this section to reflect the higher per-visit amounts that will be used to calculate the LUPA payments.

Section 484.235

We revised paragraph (b) to reflect the use of billable visit dates as the defining points for the PEP adjustment.

Section 484.237

We revised paragraphs (b)(1) and (b)(2) governing the SCIC adjustment to reflect the use of billable visit dates to define the span of days used to calculate the proportional payments both before and after a patient experiences a significant change in condition.

Section 484.240

We revised paragraph (d) to reflect the higher per-visit amounts that will be used to calculate the imputed costs for each episode for outlier payment determination.

C. Effects of This Final Rule

Section 1895(b)(3)(A)(i) of the Act requires the computation of a standard prospective payment amount to be initially based on the most recent audited cost-report data available to the Secretary. In accordance with this section of the Act, the primary data source in developing the cost basis for the 60-day episode payments was the audited cost- report sample of HHAs whose cost reporting periods ended in fiscal year 1997 (that is, ending on or after October 1, 1996 through September 30, 1997). We also adopted the most current complete utilization data available from 1998.

Table 11 below illustrates the proportion of HHAs that are likely to be affected. This table reflects how agencies would be paid under PPS versus how they would be paid under IPS. The limits under IPS were determined by updating the per-visit limits in effect for FY 2000 by the market basket minus 1.1 percent and updating each agency's per-beneficiary cap for FY 2000 by this same percentage. For each agency in the audited cost report data set, we updated their costs from FY 1997 to FY 2001 by our best estimate of HHA cost increases during this period. We then compared each agency's FY 2001 costs to the IPS limits to determine their IPS payment in FY 2001. To determine each agency's payment under PPS, we translated the cost report data into 60-day episodes and used the average case-mix for urban/rural and provider type as a proxy. We extrapolated the audited cost report data to reflect the total Medicare HHA distribution. We obtained average case-mix values based on the type of provider and whether the HHA was urban or rural from the Abt data set. We then multiplied the agency's expected number of episodes in FY 2001 by the wage-adjusted and case-mix- adjusted episode payment to obtain the agency's expected PPS payment. The PPS payment was then compared to the IPS payment.

TABLE 11.—IMPACT OF THE HOME HEALTH PROSPECTIVE PAYMENT AMOUNTS ON HOME HEALTH AGENCIES BY TYPE AND LOCATION FOR THE 563 AUDITED COST REPORT SAMPLE AGENCIES

Type of agency	Percentage change from IPS to PPS
All Agencies	0.0
By Urban/Rural and Provider Type:	
Rural:	
Freestanding: For-Profit	−7.50
Governmental	29.98
Non-Profit	13.28
Provider Based	5.31
Urban:	
Freestanding: For-Profit	−14.25
Governmental	20.58
Non-Profit	18.89
Provider Based	−2.50
By Provider Type:	
Freestanding: For-Profit	−12.77
Governmental	26.50
Non-Profit	17.88
Provider Based	−1.03
By Urban/Rural:	
Rural Agencies	5.94
Urban Agencies	−0.08
By Region:	
Midwest States	14.77
Northeast States	15.37
Southern States	−16.75
Western States	17.84

Table 11 represents the projected effects of the HHA PPS and is based on the 563 providers in the audited cost-report sample weighted to the national total of HHAs. This sample has been adjusted by the most recent market basket factors to reflect the expected cost increases occurring between the cost-reporting periods for the data contained in the database and September 30, 2001.

This impact table compares the effect on categories of HHAs in moving from the IPS payment methodology to the PPS payment methodology. These cost limits have already had the effect of reducing many extremes in the cost of the system; therefore, as a result of IPS, a majority of HHA providers are currently held at the median national cost per-beneficiary or below. It should be noted that HHAs will have had 2 or more years experience under this system before PPS implementation. The effect of IPS payment restraint combined with the improvements in this final rule have significantly reduced the degree of variation between providers and regions as well as the overall impact of the rule. Because we believe it was important that the impact tables provide the most accurate representation possible, it was necessary for us to use the data set drawn upon from the audited cost report file. This file of course is nationally representative and these data become decreasingly valid when divided into smaller geographic areas. Thus, the lowest level of analysis we could reasonably provide using this data is the four census regions. Any finer level of analysis would introduce a level of statistical error that we believe would be unacceptable.

Column one of this table divides HHAs by a number of characteristics including provider type, region, and urban versus rural location. For purposes of this impact table four regions have been defined: Northeast, South, Midwest, and West. The Northeast Region consists of Connecticut, Massachusetts, Maine, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, and the Virgin Islands. The South Region consists of Alabama, Arkansas, the District of Columbia, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The Midwest Region consists of Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, North Dakota, Nebraska, Ohio, South Dakota, and Wisconsin. The West Region consists of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, New Mexico, Nevada, Oregon, Utah, Washington, and Wyoming.

Column two shows the percentage change in Medicare payments a particular category of HHAs would experience in moving from the IPS payment methodology to the final PPS payment methodology. Because the statute requires aggregate payments under the HHA PPS and HHA IPS payment methodology to be budget neutral, the effect on agencies in the aggregate is zero.

Rural freestanding for-profit HHAs experience an 7.50 percent decrease in moving from the IPS payment methodology to the PPS payment methodology. Rural freestanding governmental HHAs experience an 29.98 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Rural freestanding nonprofit HHAs experience an 13.28 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Rural provider-based HHAs, in the aggregate, experience an 5.31 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Rural agencies, in the aggregate, experience an 5.94 percent increase in moving from the IPS payment methodology to the PPS payment methodology.

Urban freestanding for-profit HHAs experience an 14.25 percent decrease in moving from the IPS payment methodology to the PPS payment methodology. Urban freestanding governmental HHAs experience an 20.58 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Urban freestanding nonprofit HHAs experience an 18.89 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Urban provider-based HHAs, in the aggregate, experience an 2.50 percent decrease in moving from the IPS payment methodology to the PPS payment methodology. Urban agencies, in the aggregate, experience an 0.08 percent decrease in moving from the IPS payment methodology to the PPS payment methodology.

The current IPS cost limits have been criticized as providing better financial treatment of urban providers relative to rural providers. The HHA PPS system, which is based on patient characteristics, tends to level the playing field; thus, rural providers, in general, fare relatively better than urban providers. The largest impact on urban providers is in the urban freestanding for-profit category where it can be argued that historical costs have been disproportionately high compared to other providers for reasons unrelated to the relative needs of the patients they serve.

Freestanding for-profit HHAs, in the aggregate, experience an 12.77 percent decrease in moving from the IPS payment methodology to the PPS payment methodology. Freestanding governmental HHAs, in the aggregate, experience an 26.50 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Freestanding nonprofit HHAs, in the aggregate, experience an 17.88 percent increase in moving from the IPS payment methodology to the PPS payment methodology. Provider-based HHAs, in the aggregate, experience an 1.03 percent decrease in moving from the IPS payment methodology to the PPS payment methodology.

It should be noted that governmental providers fare relatively better under the HHA PPS system than other types of providers. In part, this is because the HHA PPS system is driven primarily by the needs of patients rather than utilization incentives. Thus, governmental providers are less affected by the IPS payment methodology because their costs have been historically lower and visit utilization per episode is much lower. On average, governmental agencies have reported lower average costs per visit as well as fewer visits per episode. It should be noted that this category of HHAs accounts for only 3.8 percent of total home health expenditures and, therefore, the large increase attributed to them has little impact in the aggregate system costs.

Provider-based agencies historically tended to have, as a group, higher per-visit costs. As could be anticipated, the payment differential reflected in this impact table for provider-based agencies is in a negative direction, but relatively modest, probably due to the cost discipline already in place due to IPS.

HHAs in the Midwest region experience an 14.77 percent increase in moving from the IPS payment methodology to the PPS payment methodology. HHAs in the Northeast region experience an 15.37 percent increase in moving from the IPS payment methodology to the PPS payment methodology. HHAs in the South region experience an 16.75 percent decrease in moving from the IPS payment methodology to the PPS payment methodology. HHAs in the West region experience an 17.84 percent increase in moving from the IPS

payment methodology to the PPS payment methodology.

We would have preferred to provide an impact table with more regions; however, the limitations of our data prevented us from obtaining provider data at a lower level than the four major regions. However, this regional breakdown does reflect what one might expect in moving from our current IPS cost limitations payment methodology to a national PPS payment methodology. Medicare payments have historically varied by region without regard to the relative needs/conditions of patients; therefore, that region that had the highest unexplained costs for home health services is the most impacted area (South region). In contrast, the Midwest, Northeast, and West regions fare relatively well by comparison. It must be noted that in a payment methodology system that is legislatively required to achieve budget neutrality, any effort to increase payments to those regions more affected by a national payment system necessarily results in a reduction of payments to those regions that have historically restrained costs under home health.

It should be noted that to the degree that agencies respond to the incentives of the prospective payment system and apply resources commensurate with the measured characteristics of their patients, the impacts predicted in this model will further be reduced.

D. Rural Hospital Impact Statement

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

We have not prepared a rural impact statement since we have determined, and the Secretary certifies, that this rule would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism. We have determined that this final rule would not have substantial direct effects on the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Amend part 409 as set forth below:

1. Revise the authority citation for part 409 to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Amend § 409.43 as follows:

A. Revise paragraphs (c) and (e).

B. Amend paragraph (f) by removing the phrase ''62-day'' and adding in its place the phrase ''60-day.''

§ 409.43 Plan of care requirements.

* * * * *

(c) *Physician signature.* (1) *Request for Anticipated payment signature requirements.* If the physician signed plan of care is not available at the time the HHA requests an anticipated payment of the initial percentage prospective payment in accordance with § 484.205, the request for the anticipated payment must be based on—

(i) A physician's verbal order that—

(A) Is recorded in the plan of care;

(B) Includes a description of the patient's condition and the services to be provided by the home health agency;

(C) Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care; and

(D) Is copied into the plan of care and the plan of care is immediately submitted to the physician; or

(ii) A referral prescribing detailed orders for the services to be rendered that is signed and dated by a physician.

(2) *Reduction or disapproval of anticipated payment requests.* HCFA has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal orders as specified in paragraph (c)(1)(i) and/or a prescribing referral as specified in (c)(1)(ii) of this section and is not a Medicare claim for purposes of the Act (although it is a ''claim'' for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the Civil Monetary Penalties Law (as defined in 42 U.S.C. 1320a–7a (i) (2)), the Civil False Claims Act (as defined in 31 U.S.C. 3729(c)), and the Criminal False Claims Act (18 U.S.C. 287)), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.

(3) *Final percentage payment signature requirements.* The plan of care must be signed and dated—

(i) By a physician as described who meets the certification and recertification requirements of § 424.22 of this chapter; and

(ii) Before the claim for each episode for services is submitted for the final percentage prospective payment.

(4) *Changes to the plan of care signature requirements.* Any changes in the plan must be signed and dated by a physician.

* * * * *

(e) *Frequency of review.* (1) The plan of care must be reviewed by the physician (as specified in § 409.42(b)) in consultation with agency professional personnel at least every 60 days or more frequently when there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition resulting in a change in the case-mix assignment; or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Each review of a beneficiary's plan of care must contain the signature of the

physician who reviewed it and the date of review.

* * * * *

3. In § 409.100, revise paragraph (a) to read as follows:

§ 409.100 To whom payment is made.

(a) *Basic rule.* Except as provided in paragraph (b) of this section—

(1) Medicare pays hospital insurance benefits only to a participating provider.

(2) For home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA, payment is made to the HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Amend part 410 as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 410.150, republish the introductory text to paragraph (b) and add new paragraph (b)(19) to read as follows:

§ 410.150 To whom payment is made.

* * * * *

(b) *Specific rules.* Subject to the conditions set forth in paragraph (a) of this section, Medicare Part B pays as follows:

* * * * *

(19) To a participating HHA, for home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Amend part 411 as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 411.15, republish the introductory text to the section, and add a new paragraph (q) to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage:

* * * * *

(q) A home health service (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) as defined in section 1861(m) of the Act furnished to an individual who is under a plan of care of an HHA, unless that HHA has submitted a claim for payment for such services.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

D. Amend part 413 as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a),(i) and (n), 1861(v), 1871, 1881, 1883, and 1866 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l(a),(i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.1, add a new paragraph (h) to read as follows:

§ 413.1 Introduction.

* * * * *

(h) *Payment for services furnished by HHAs.* The amount paid for home health services as defined in section 1861(m) of the Act (except durable medical equipment and the covered osteoporosis drug as provided for in that section) that are furnished beginning on or after October 1, 2000 to an eligible beneficiary under a home health plan of care is determined according to the prospectively determined payment rates for HHAs set forth in part 484, subpart E of this chapter.

§ 413.64 [Amended]

3. Amend § 413.64 by:

A. Amending paragraph (h)(1) to remove the phrase ''and for both Part A and Part B HHA services'' at the end of the paragraph.

B. Removing paragraph (h)(2)(iv) and redesignating paragraphs (h)(2)(v) and (h)(2)(vi) as paragraphs (h)(2)(iv) and (h)(2)(v) respectively.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

E. Amend part 424 as set forth below:

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1895hh).

2. In § 424.22, revise paragraph (b)(1) to read as follows:

§ 424.22 Requirements for home health services.

* * * * *

(b) *Recertification.* (1) *Timing and signature of recertification.* Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan of care. The recertification is required at least every 60 days when there is a—

(i) Beneficiary elected transfer; or

(ii) Discharge and return to the same HHA during the 60-day episode.

* * * * *

PART 484—HOME HEALTH SERVICES

F. Amend part 484 as set forth below:

1. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh), unless otherwise indicated.

2. Revise the heading for part 484 to read as set forth above.

3. Add a new paragraph (a)(3) to § 484.1 to read as follows:

§ 484.1 Basis and scope.

(a) *Basis and scope.* * * *

(3) Section 1895 provides for the establishment of a prospective payment system for home health services covered under Medicare.

* * * * *

§ 484.18 [Amended]

4. In § 484.18, in paragraph (b), remove the phrase ''62 days'' and in its place add the phrase ''60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode.''

5. In § 484.55, revise paragraph (d)(1) to read as follows:

§ 484.55 Condition of participation: Comprehensive assessment of patients.

* * * * *

(d) *Standard: Update of the comprehensive assessment.*

* * * * *

(1) The last five days of every 60 days beginning with the start-of-care date, unless there is a—

(i) Beneficiary elected transfer;

(ii) Significant change in condition resulting in a new case-mix assignment; or

(iii) Discharge and return to the same HHA during the 60-day episode.

* * * * *

6. Add and reserve a new subpart D.

7. Add a new subpart E to read as follows:

Subpart E—Prospective Payment System for Home Health Agencies

Sec.

484.200 Basis and scope.
484.202 Definitions.
484.205 Basis of payment.
484.210 Data used for the calculation of the national prospective 60-day episode payment.
484.215 Initial establishment of the calculation of the national 60-day episode payment.
484.220 Calculation of the national adjusted prospective 60-day episode payment rate for case-mix and area wage levels.
484.225 Annual update of the national adjusted prospective 60-day episode payment rate.
484.230 Methodology used for the calculation of the low-utilization payment adjustment.
484.235 Methodology used for the calculation of the partial episode payment adjustment.
484.237 Methodology used for the calculation of the significant change in condition payment adjustment.
484.240 Methodology used for the calculation of the outlier payment.
484.245 Accelerated payments for home health agencies.
484.250 Patient assessment data.
484.260 Limitation on review.

Subpart E—Prospective Payment System for Home Health Agencies

§ 484.200 Basis and scope.

(a) *Basis.* This subpart implements section 1895 of the Act, which provides for the implementation of a prospective payment system (PPS) for HHAs for portions of cost reporting periods occurring on or after October 1, 2000.

(b) *Scope.* This subpart sets forth the framework for the HHA PPS, including the methodology used for the development of the payment rates, associated adjustments, and related rules.

§ 484.202 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the clinical model.

Discipline means one of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Home health market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

§ 484.205 Basis of payment.

(a) *Method of payment.* An HHA receives a national prospective 60-day episode payment of a predetermined rate for a home health service previously paid on a reasonable cost basis (except the osteoporosis drug defined in section 1861(kk) of the Act) as of August 5, 1997. The national 60-day episode payment is determined in accordance with § 484.215. The national prospective 60-day episode payment is subject to the following adjustments and additional payments:

(1) A low-utilization payment adjustment (LUPA) of a predetermined per-visit rate as specified in § 484.230.

(2) A partial episode payment (PEP) adjustment due to an intervening event defined as a beneficiary elected transfer or a discharge and return to the same HHA during the 60-day episode, that warrants a new 60-day episode payment during an existing 60-day episode, that initiates the start of a new 60-day episode payment and a new physician certification of the new plan of care. The PEP adjustment is determined in accordance with § 484.235.

(3) A significant change in condition (SCIC) payment adjustment due to the intervening event defined as a significant change in the patient's condition during an existing 60-day episode. The SCIC adjustment occurs when a beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. The SCIC adjustment is determined in accordance with § 484.237.

(4) An outlier payment is determined in accordance with § 484.240.

(b) *Episode payment.* The national prospective 60-day episode payment represents payment in full for all costs associated with furnishing home health services previously paid on a reasonable cost basis (except the osteoporosis drug listed in section 1861(m) of the Act as defined in section 1861(kk) of the Act) as of August 5, 1997 unless the national 60-day episode payment is subject to a low-utilization payment adjustment set forth in § 484.230, a partial episode payment adjustment set forth at § 484.235, a significant change in condition payment set forth at § 484.237, or an additional outlier payment set forth in § 484.240. All payments under this system may be subject to a medical review adjustment reflecting beneficiary eligibility, medical necessity determinations, and HHRG assignment. DME provided as a home health service as defined in section 1861(m) of the Act continues to be paid the fee schedule amount.

(1) *Split percentage payment for initial episodes.* The initial percentage payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage adjusted 60-day episode rate. Split percentage payments are made in accordance with requirements at § 409.43(c) of this chapter.

(2) *Split percentage payment for subsequent episodes.* The initial percentage payment for subsequent episodes is paid to an HHA at 50 percent of the case-mix and wage adjusted 60-day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60-day episode rate. Split percentage payments are made in accordance with requirements at § 409.43(c) of this chapter.

(c) *Low-utilization payment.* An HHA receives a national 60-day episode payment of a predetermined rate for home health services previously paid on a reasonable cost basis as of August 5, 1997, unless HCFA determines at the end of the 60-day episode that the HHA furnished minimal services to a patient during the 60-day episode. A low-utilization payment adjustment is determined in accordance with § 484.230.

(d) *Partial episode payment adjustment.* An HHA receives a national 60-day episode payment of a predetermined rate for home health services previously paid on a reasonable cost basis as of August 5, 1997, unless HCFA determines an intervening event, defined as a beneficiary elected transfer, or discharge and return to the same HHA during a 60-day episode, warrants a new 60-day episode payment. The PEP adjustment would not apply in situations of transfers among HHAs of common ownership as defined in § 424.22 of this chapter. Those situations would be considered services provided under arrangement on behalf

of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA. The transferring HHA in situations of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided under arrangements to be paid. The discharge and return to the same HHA during the 60-day episode is only recognized in those circumstances when a beneficiary reached the goals in the original plan of care. The original plan of care must have been terminated with no anticipated need for additional home health services for the balance of the 60-day episode. If the intervening event warrants a new 60-day episode payment and the new physician certification of a new plan of care, the initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care. A partial episode payment adjustment is determined in accordance with § 484.235.

(e) *Significant change in condition adjustment.* The HHA receives a national 60-day episode payment of a predetermined rate for home health services paid on a reasonable cost basis as of August 5, 1997, unless HCFA determines an intervening event defined as a beneficiary experiencing a significant change in condition during a 60-day episode that was not envisioned in the original plan of care occurred. In order to receive a new case-mix assignment for purposes of payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in the treatment approach in the patient's plan of care. The total significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both prior and after the patient experienced a significant change in condition during the 60-day episode. A SCIC adjustment is determined in accordance with § 484.237.

(f) *Outlier payment.* An HHA receives a national 60-day episode payment of a predetermined rate for a home health service paid on a reasonable cost basis as of August 5, 1997, unless the imputed cost of the 60-day episode exceeds a threshold amount. The outlier payment is defined to be a proportion of the imputed costs beyond the threshold. An outlier payment is a payment in addition to the national 60-day episode payment. The total of all outlier payments is limited to 5 percent of total outlays under the HHA PPS. An outlier payment is determined in accordance with § 484.240.

§ 484.210 Data used for the calculation of the national prospective 60-day episode payment.

To calculate the national prospective 60-

day episode payment, HCFA uses the following:

(a) Medicare cost data on the most recent audited cost report data available.

(b) Utilization data based on Medicare claims.

(c) An appropriate wage index to adjust for area wage differences.

(d) The most recent projections of increases in costs from the HHA market basket index.

(e) OASIS assessment data and other data that account for the relative resource utilization for different HHA Medicare patient case-mix.

§ 484.215 Initial establishment of the calculation of the national 60-day episode payment.

(a) *Determining an HHA's costs.* In calculating the initial unadjusted national 60-day episode payment applicable for a service furnished by an HHA using data on the most recent available audited cost reports, HCFA determines each HHA's costs by summing its allowable costs for the period. HCFA determines the national mean cost per visit.

(b) *Determining HHA utilization.* In calculating the initial unadjusted national 60-day episode payment, HCFA determines the national mean utilization for each of the six disciplines using home health claims data.

(c) *Use of the market basket index.* HCFA uses the HHA market basket index to adjust the HHA cost data to reflect cost increases occurring between October 1, 1996 through September 30, 2001.

(d) *Calculation of the unadjusted national average prospective payment amount for the 60-day episode.* HCFA calculates the unadjusted national 60-day episode payment in the following manner:

(1) By computing the mean national cost per visit.

(2) By computing the national mean utilization for each discipline.

(3) By multiplying the mean national cost per visit by the national mean utilization summed in the aggregate for the six disciplines.

(4) By adding to the amount derived in paragraph (d)(3) of this section, amounts for nonroutine medical supplies, an OASIS adjustment for estimated ongoing reporting costs, an OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to October 1, 2000. The resulting amount is the unadjusted national 60-day episode rate.

(e) *Standardization of the data for variation in area wage levels and case-mix.* HCFA standardizes—

(1) The cost data described in paragraph (a) of this section to remove the effects of geographic variation in wage levels and variation in case-mix;

(2) The cost data for geographic variation in wage levels using the hospital wage index; and

(3) The cost data for HHA variation in case-mix using the case-mix indices and other data that indicate HHA case- mix.

§ 484.220 Calculation of the adjusted national prospective 60-day episode payment rate for case-mix and area wage levels.

HCFA adjusts the national prospective 60-day episode payment rate to account for—

(a) HHA case-mix using a case-mix index to explain the relative resource utilization of different patients; and

(b) Geographic differences in wage levels using an appropriate wage index based on the site of service of the beneficiary.

§ 484.225 Annual update of the unadjusted national prospective 60-day episode payment rate.

(a) HCFA updates the unadjusted national 60-day episode payment rate on a fiscal year basis.

(b) For fiscal year 2001, the unadjusted national 60-day episode payment rate is adjusted using the latest available home health market basket index factors.

(c) For fiscal years 2002 and 2003, the unadjusted national prospective 60-day episode payment rate is updated by a factor equal to the applicable home health market basket minus 1.1 percentage points.

(d) For subsequent fiscal years, the unadjusted national rate is equal to the rate for the previous fiscal year increased by the applicable home health market basket index amount.

§ 484.230 Methodology used for the calculation of the low-utilization payment adjustment.

An episode with four or fewer visits is paid the national per-visit amount by

discipline updated annually by the applicable market basket for each visit type. The national per-visit amount is determined by using cost data set forth in § 484.210(a) and adjusting by the appropriate wage index based on the site of service for the beneficiary.

§ 484.235 Methodology used for the calculation of the partial episode payment adjustment.

(a) HCFA makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event described in § 484.205(d).

(b) The original 60-day episode payment is adjusted to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

(c) The partial episode payment is calculated by determining the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

§ 484.237 Methodology used for the calculation of the significant change in condition payment adjustment.

(a) HCFA makes a SCIC payment adjustment to the original 60-day episode payment that is interrupted by the intervening event defined in § 484.205(e).

(b) The SCIC payment adjustment is calculated in two parts.

(1) The first part of the SCIC payment adjustment reflects the adjustment to the level of payment prior to the significant change in the patient's condition during the 60-day episode. The first part of the SCIC adjustment is determined by taking the span of days (the first billable visit date through and including the last billable visit date) prior to the patient's significant change in condition as a proportion of 60 multiplied by the original episode amount.

(2) The second part of the SCIC payment adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day episode. The second part of the SCIC adjustment is calculated by using the span of days (the first billable visit date through and including the last billable visit date) through the balance of the 60-day episode.

(c) The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the total SCIC adjustment determined at the end of the 60-day episode.

§ 484.240 Methodology used for the calculation of the outlier payment.

(a) HCFA makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(b) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode or the total significant change in condition adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(c) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(d) HCFA imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(e) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than 5 percent of total payment under home health PPS.

§ 484.245 Accelerated payments for home health agencies.

(a) *General rule.* Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the intermediary in making payment to the HHA.

(b) *Approval of payment.* An HHA's request for an accelerated payment must be approved by the intermediary and HCFA.

(c) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(d) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

§ 484.250 Patient assessment data.

An HHA must submit to HCFA the OASIS data described at § 484.55(b)(1) and (d)(1) in order for HCFA to administer the payment rate methodologies described in §§ 484.215, 484.230, 484.235, and 484.237.

§ 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 19, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: June 22, 2000.

Donna E. Shalala,

Secretary.

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